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Social desirability and aggression under trans-situational conditions.

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SOCIAL DESIRABILITY AND AGGRESSION UNDER TRANS-SITUATIONAL CONDITIONS

A Thesis Presented

By

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Investigated the relationship between aggression and social desirability in 50 male hospitalized psychiatric patients. Used two measures of social desirability, the Edwards and Marlowe-Crowne, and two measures of aggression, one based on reports from hospital records, and one based on self-report. Found a significant inverse relationship between the variables in three out of four comparisons and a significant point-biserial correlation between the two measures of aggression. Discusses results from a consistency of cross-situational behavior perspective and cites methodological limitations of present study, offers suggestions concerning further research.

(ABSTRACT)

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C H A P T E R I

INTRODUCTION

The concept of response-sets of specific natures was first proposed by Cronbach (1946) in an effort to bring some organization to a personality-testing movement beset by the problem of response dissimulation. The most notable of the response-sets proposed by Cronbach was the "acquiescence set," the tendency to agree with most test items regardless of content. Edwards (1953a, 1967) expanded the original concept and isolated a tendency to endorse items in response to their perceived social desirability. Since its conception, the social-desirability response-set has generated a continuing flow of research.

The social desirability scale developed by Edwards was composed of items drawn from the Minnesota Multiphasic Personality Inventory (MMPI). It was originally designed to be used as a method of correcting for some of the error variance in comprehensive personality tests such as the MMPI and the Edwards Personal Preference Schedule (1953b). This history may have contributed to the fact that most of the research employing the Edwards Social Desirability Scale (ESDS) has focused on test-taking situations and has not investigated the generality of the social

desirability disposition. One study which went beyond the test correction-factor use of the ESDS was that of Edwards & Walker (1961). This study investigated the utility of the ESDS as a short form of the MMPI. However, this extension of the use of the variable maintained a test-taking focus. Another early study which employed this instrument (Allison & Hunt, 1959) did move away from the personality testing area and will be discussed later in this paper.

The social desirability scale devised by Edwards was, like most pioneer efforts, somewhat limited. The items Edwards used in the ESDS were, as mentioned earlier, drawn from the clinical scales of the MMPI. Because of this, these items have a dual content: a social desirability content and a psychopathology content which they were originally designed to assess. In an effort to produce a less confounded measure of social desirability Marlowe & Crowne (1960) devised and reported on a new scale, ostensibly free of any manifest psychopathology content. These authors argued that high scores on the ESDS could simply reflect low psychopathology on the part of the subjects, and that the pathology content could thus inflate the scores. In their extensive book on the subject (Crowne & Marlowe, 1964) the authors detailed the methods by which any pathology content was minimized in

their scale items. In this work they also delineate the underlying construct which they believe is measured by their scale: a need for approval. The evidence concerning the validity of this construct is ambiguous and it is beyond the scope of the present paper to present and analyze this evidence since a formal test of this hypothesis is not the purpose of the current investigation. It should be stated, however, that if the predictions of the present study are supported by the data, such a result would be completely consistent with the need for approval hypothesis. While the Marlowe-Crowne Social Desirability Scale (MCSDS) has been used without specification of any underlying construct (e.g., Klassen, Hornstra & Anderson, 1975), the present author is persuaded that a need for approval (and concomitantly a need to avoid disapproval) is the most logical motive to ascribe to those who demonstrate high MCSDS scores.

Although the need for approval construct is not universally accepted, it has been extensively utilized and discussed in the literature. The studies cited below, which have adopted this construct and employed the MCSDS typically describe the high scorers as "approval-motivated." These studies have found high MCSDS scorers to be more compliant, more subject to persuasion (in defined tasks), and more conforming in a variety of situations.

Barthel & Crowne (1962) found that high MCSDS subjects employed inhibitory perceptual defenses in a taboo-word recognition task. Strickland & Crowne (1963) found that high scorers terminated therapy against advice in much greater numbers than did low scorers, a "leaving the field" defense. Strickland & Crowne (1962) and Crowne & Liverant (1963) found these subjects to be much more socially conforming in situations which "simulated group pressure" in the case of the former, and in two variants of Asch-type situations in the latter. Crowne & Strickland (1961) and Marlowe (1962) found them to be more responsive to verbal conditioning. Cravens (1975) found high MCSDS scorers more willing to self-disclose when informed that the results would be made public (in a lecture or book) than when told the results would be kept private. Low scorers in this study demonstrated the opposite pattern.

Aggression has been the variable of interest in at least two studies employing the ESDS and two employing the MCSDS. Allison & Hunt (1959) separated subjects into high and low groups based on ESDS scores, and used a paper-and-pencil test to assess aggressive responses to three categories of frustration: aggression socially justified; aggression socially unjustified; and social aspect un-specified or ambiguous. They found that high social de-sirability scorers expressed significantly fewer aggressive responses in the unspecified condition than did low scorers.

Reznikoff & Dollin (1961) administered the ESDS to 48 psychiatric inpatients who were then divided into four groups based on their scores. The TAT was then administered to them and two judges using a special scoring procedure, evaluated the TAT's for both overt and covert aggression (hostility). There were no significant differences between the four groups (analysis of variance) on overt, covert, or total aggression. A sign-test, however, which compared overt to covert for each subject in the two extreme ESDS groups showed that more subjects in the high group manifested a greater degree of covert than overt aggression. No consistent direction was found for the low scorers.

Conn & Crowne (1964) sought to test the hypothesis that repressive ego defenses are characteristic of high social desirability scorers. They devised a procedure in which 74 male and female undergraduates were given the MCSDS then randomly divided into two groups. The experimental subjects were exposed to a condition in which they were introduced to an experimental confederate as if he were another subject. The two "subjects" were then asked to participate in a game-matrix with cash payoffs. The subjects were told that if they and "the other subject" each pressed Black (cooperative strategy) each would win $3. If both pressed Red (competitive strategy) each would win 10¢, but if one pressed Black and the other Red (mixed

strategy) Black would receive nothing but Red would win $5. After explaining this and conducting some practice trials the experimenter would be called out of the room and the confederate would suggest a deal to the subject, to each press Black on every trial and thus maximize their winnings. The experimenter would then return and the game would begin, with the subject pressing Black but the confederate pressing Red on each trial, in direct violation of their "deal." Control subjects were not exposed to this "hostility-arousing" game, but were paired with a confederate and exposed to a rating task for a period of time equal to that of the hostility game. All subjects were later exposed to a euphoria condition similar to that of Schacter & Singer (1962).

Although this study contained some additional experimental procedures, the foregoing defines the aspect most germane to the present paper: the subjects were strongly provoked. In a later phase of the study the subjects were given the opportunity both to directly confront, and later to describe their reactions to "the other subject." The subjects could react both verbally and by a forced-choice adjective-pair questionnaire administered by the experimenter. The results indicated that high scorers inhibited their aggressive responses while low scorers expressed them clearly.

Fishman (1965) collected MCSDS scores on 60 female undergraduates and performed a median-split on these scores to form high and low groups. The subjects were then assigned (in a balanced high/low order) to one of two frustration conditions, arbitrary or non-arbitrary, or to a control group. Baseline bloodpressure was taken for each subject at the start of the experimental session and again following the experimental manipulation. After the initial manipulation the subjects were asked to fill out a Research Evaluation Questionnaire, which allowed them to rate the experiment and the experimenter as to form and conduct, on a 10-point positive/negative scale. Prior to filling this out, the subjects had been instructed that the experimenter was seeking a position at the university and that negative comments on the questionnaire could influence the decision on his application. The questionnaire contained 18 items, 7 of which referred to the experimenter. The measure of aggression was the mean score on these 7 items, for each subject. The results showed that high MCSDS scorers expressed significantly less aggression than did low scorers.

Klassen, Hornstra & Anderson (1975) conducted a study which examined a number of variables in relation to social desirability as measured by the MCSDS. These authors reported a significant negative correlation

(-.35, $p<.001$ level) between agression and social desirability from their data. The measure of aggression used in this study consisted of 3 items on a 300-item questionnaire, and these results must accordingly be interpreted with caution.

The consistent thread which links these studies is the finding of some degree of inverse relationship between social desirability and the expression of aggression. While high scorers appear to inhibit their expression of aggression low scorers appear much more likely to express it. There is some evidence that at least two other factors may influence this relationship: cultural definition of the situation (Allison & Hunt, 1959), and status of the agent of provocation (Larsen, Martin, Ettinger & Nelson, 1976). Both of these can be logically viewed as sub-factors of social desirability. The cultural definition of the situation relates to whether or not aggression is socially justified and for this we can substitute "approved." There are long-standing social mores which, in certain situations, not only allow for the (limited) expression of aggression but actually press for it. Such injunctions as "stand up for your rights," "don't be wishy-washy," don't let yourself be pushed around," etc., are an integral part of our culture. In recent years psychologists have conducted regular training programs designed to teach

them to assert themselves in line with such injunctions. Thus, while social desirability can ordinarily be viewed as a force inhibiting the expression of aggression, it also provides for that relatively rare class of situations in which the inhibition, with respect to high scorers, is not manifested.

The status of the agent of provocation (Larsen, Martin, Ettinger & Nelson, 1976) is a factor which can at least be partially subsumed under "cultural definition" of a given situation. Authority, or other high status figures, are those toward whom the culture dictates that the greatest deference be shown. By the very nature of "status," those who are considered low on this social demension are accorded little or no deference by the culture. The findings that high social desirability scorers evidence less inhibition of their aggression toward people who are low on social status is just further evidence that the responses of high social desirability scorers are strongly shaped by social influence.

The present study is designed to extend the investigation of the relationship between social desirability and aggression into free-field situations. The relationship has thus far been demonstrated by studies with the ESDS as well as the MCSDS, but only in controlled and manipulated

experimental situations. While the experimental situation allows for a range of controls to be instituted, it also defines a restricted environment within which the relationship is demonstrated. Once a relationship has been demonstrated, a next logical step is to show that it also prevails outside of the experimental situation. A longitudinal study of high and low social desirability scorers would be ideal and this idea has been suggested (Crowne & Marlowe, 1964), with reference to the pattern of variables which have been associated with social desirability. The expense and complexity of such research, however, makes it unlikely to be undertaken. A second option would be retrospective in approach, investigating the history of subjects, relative to variables associated with social desirability. This has also been suggested (Crowne & Marlowe, 1964) but can often be forestalled through a lack of accurate historical data.

The present study will employ a design based on the second option mentioned above. It will meet the concern of accurate historical data by using psychiatric inpatients as subjects, and examining their hospital records for report of overt physical and verbal aggression. Because aggression is both frightening and disruptive to hospital routine, it is a class of behaviors which staff are very diligent about reporting and recording. The structure

of a psychiatric hospital also contains some inherent control for the "status" factor mentioned earlier. The staff members of such a facility are very clearly authority figures who can influence if not dictate the privileges or penalties which accrue to any given patient. For this reason, whether an act of aggression is committed against a staff member directly or against another patient in the presence of a staff member, the offender is overriding any status concerns he may have. An act of aggression would not be likely to be reported in the records unless it occurred within the above guidelines and so the status factor should not be of great concern within the present study.

The second moderating variable mentioned above, cultural definition, is also inherently controlled for within this milieu. There is a strong and heavily reinforced proscription against aggression throughout the facility within which this study will be conducted. The only exception to this iron-clad rule relates to self-defense if one is assaulted. It would be unlikely to find an incident report in the record of a victim of such an assault, unless he sustained injury requiring treatment. In any case, the report would identify him as the victim, thus removing the report as a concern of this study.

In order to best assess the relationship of interest, the present study will employ two separate and independent measures of social desirability: the ESDS and the MCSDS. There will also be two measures of aggression used: the major one based on historical data, and a second one based on self-report. The primary purpose of this study is to test the hypothesis that social desirability scores are inversely related to the expression of aggression. While this relationship should exist with respect to each of the measures of social desirability, the use of psychiatric patients as subjects can be expected to inflate the ESDS scores due to the pathology content of its items. Because of this inflation, a difference in the magnitude of the relationship with aggression may exist in favor of the MCSDS. It is expected that there will be a significant positive correlation between the two measures of aggression employed.

C H A P T E R I I

METHOD

Subjects.

The subjects were 50 male, psychiatric inpatients at the Veterans Administration Hospital, Northampton, Massachusetts. Subjects were between the ages of 21 and 50 ($\bar{X}$ = 34.06, SD = 7.4) and included 46 diagnosed as psychotic (primarily schizophrenic) and 6 diagnosed non-psychotic. The non-psychotics were balanced across groups with three in each. The subjects were selected through a review of hospital records designed to produce two 25-member groups dichotomized on the variable "overt aggression." It was planned to establish these groups before requesting participation from any subjects. This, however, proved impractical because the hospital turn-over rate resulted in some of the first patients qualified to become subjects being discharged from the hospital before their participation could be requested. In practice, therefore, subjects were approached as soon as was practical after their identification from records and were requested to participate as described in the Procedure section below. The subjects were required to have had a minimum period of hospitalization of six months, either from a single

hospitalization or from an aggregate of two or more, and a maximum period of hospitalization of five years.

The record review encompassed the most recent one-year period and subjects with less hospitalization than this were balanced across groups. The records of approximately 400 patients were examined during the selection of the 50 subjects finally employed in this study. The majority were rejected due to age ineligibility, but a significant minority failed to meet either the maximum or minimum aggression-score criterion. A much smaller number were rejected from consideration due to chronic (over 5 years' duration) hospitalization. There were also 9 potential High and 5 pottential Low subjects who refused to participate after having been identified through the record review procedure. Until the last week of the data collection period, the first patients whose records met criteria were requested to participate and in all but the above-mentioned cases they agreed to do so. During the final week of data collection a deliberate effort was made to locate one black, high-aggression subject, and three Low-aggression subjects in their twenties, in order to balance the groups on race (22 white and 3 black in each group) and age (High $\bar{X}$ = 34.24, Low $\bar{X}$ = 33.88)

Measures.

A 10-item Aggression-Point Scale (Appendix A) developed for this study was used to produce the initial dichotomy. The 33-item Marlowe-Crowne Social Desirability Scale (MCSDS), the 39-item Edwards Social Desirability Scale (ESDS), and an 11-item self-report measure of behavioral aggression (Appendix B) developed for this study were given to all subjects who agreed to participate. An Informed Consent Sheet (Appendix C) was read to all potential subjects and those who agreed to participate signed this.

Procedure.

A review of patients' records throughout the hospital was conducted by the author for the purpose of identifying 25 High-aggression and 25 Low-aggression subjects. Patients' records were examined for reports of overt verbal and physical aggression, and each such incident reported was assigned a point value based on the Aggression-Point Scale. Inclusion in the High group required that a minimum of 40 points be accumulated during the period reviewed. Inclusion in the Low group required that no more than 5 points be accumulated during such review. The above values were selected somewhat arbitrarily to produce groups which were widely separated in their overt expression of aggression, as indicated by hospital

records. Patients whose records evidenced scores between these values (i.e., 6 through 39) were deemed ineligible for this study.

Once a qualified High or Low subject was located through record search on a given ward, an attempt was made to identify a qualified subject for the opposite group on the same ward. When this was done, the two were then asked to meet with the author and were requested to participate in the study at this same meeting. If they agreed, they filled out the forms during this same session. When initially approached, subjects were simply asked if they would talk to me for "awhile" about a study I was conducting. No one refused this request. Following this, we would move to an office or conference room where the Informed Consent Sheet would be read to the prospective subjects. This comprised the formal request to participate. If subjects asked additional questions beyond "How long will it take?" which was answered "About 30 minutes," they were referred back to the Informed Consent Sheet which stated that all questions would be answered at the end of the then current session. If a subject refused to participate at this point, he was asked to step outside until the proceedings were completed with the remaining subject.

An attempt was made to present all particpation requests in group-balanced sessions. This could not always be accomplished due to the following reasons: degree of regression and volatile nature of some of the subjects, this requiring a one-to-one interview; the lack of Low subjects on the Crisis Intervention ward where a number of the High subjects were located; and in a few cases the need to interview a subject quickly due to an upcoming transfer or discharge. A number of strategems were employed to address these problems eventuating in 30 (15 High and 15 Low) subjects having been interviewed in balanced formats and 20 (10 High and 10 Low) subjects having been interviewed either individually or in company with a member of their own group. The forms used were organized into numbered packets and no subject's name was placed on a form. The packets consisted of an ESDS, an MCSDS, and a self-report of aggression form. The foregoing also defined the order of presentation which was constant across all subjects.

After having filled out the forms, each subject was provided a brief explanation of the study and any questions they had were answered. Each subject was requested to avoid discussing the study with other patients, since some of them might themselves become subjects; all agreed to this. The subjects used in the study were drawn from 7 of the 9 major wards at the hospital.

C H A P T E R I I I

RESULTS

The subjects were divided into two groups based on levels of aggression as assessed by hospital records. The raw scores and psychiatric diagnoses of the subjects are shown in Table 1.

A t-test was applied to the means of the ESDS. Because the difference in social desirability means was predicted to follow a specific direction, with Low's scoring above High's, one-tailed tests were carried out on all means unless otherwise specified. The t-value derived for the ESDS means was significant, with $t = 1.78$, $p<.05$.

A t-test was then applied to the means of the MCSDS and produced $t = 3.02$, $p<.005$.

On the third dependent measure, the SRA, it was predicted that the groups would, on the average, score consistent with their relative group placement. A t-test of the SRA means was performed and produced $t = 5.04$, $p<.001$ (two-tailed). A point-biserial correlation between the High and Low group means on the SRA was computed to more fully assess the relationship of the two measures of aggression. This produced an r_{pb} value of .588, $p<.001$

Table 1

Raw Scores and Diagnoses for All Subjects, Dichotomized
By Aggression from Hospital Records

High					Low				
Sub.#	Diagnosis	ESDS	MCSDS	SRA	Sub.#	Diagnosis	ESDS	MCSDS	SRA
2	Chron. Alc.	20	10	20	1	Chron. Alc.	26	4	10
4	Para. Schiz.	23	10	10	3	Schiz. C.U.	22	15	4
6	" "	25	12	14	5	Para. Schiz.	22	14	11
8	" "	24	10	13	7	Schiz. C.U.	18	18	17
9	" "	31	27	5	10	" "	15	20	3
12	Schiz. C.U.	23	9	12	11	Para. Schiz.	21	18	4
14	Para. Schiz.	14	13	27	13	Schiz. C.U.	11	18	7
15	" "	25	11	7	16	" "	25	21	0
17	Explos. Pers.	21	10	9	19	Para. Schiz.	21	17	4
18	Para. Schiz.	12	7	20	20	Schiz. C.U.	20	20	5
21	Schiz., Schizo-Aff	31	22	4	22	" "	35	28	10
24	Para. Schiz.	10	9	10	23	" "	34	20	0
26	" "	30	19	14	25	Para. Schiz.	35	15	9
28	" "	16	11	12	27	" "	30	19	6
29	" "	11	8	11	32	Pers. Disorder	27	8	11
30	" "	23	14	8	34	Para. Schiz.	25	19	4
31	" "	30	9	13	36	Chron. Alc.	27	22	1
33	Explos. Pers.	18	4	20	42	Schiz., Schizo Aff	34	16	5
35	Schiz., Schizo-Aff	29	16	12	43	Para. Schiz.	30	18	11
37	Schiz., C.U.	19	17	14	45	Psych. Depress.	13	21	0
38	Para. Schiz.	19	11	15	46	Schiz. C.U.	29	16	0
39	" "	24	13	18	47	" "	34	20	2
40	" "	12	16	31	48	" "	22	13	4
41	" "	27	10	11	49	Para. Schiz.	14	10	7
44	" "	17	12	5	50	Schiz. C.U.	28	8	3

(two-tailed). The mean scores and standard deviations of these groups appear in Table 2.

The subjects were then re-grouped by means of a median-split of the SRA scores, and the relationship between aggression and social desirability was subjected to a second examination. While the groups were again divided on levels of aggression, the measure of aggression was now self-report rather than data from hospital records. The means and standard deviations of these groups appear in Table 2.

The median value of 8.5 resulted in all subjects who scored nine or less being placed in the Low group. Six subjects from each of the original groups were in opposite-group placement as a result of this re-structuring.

A t-test was applied to the ESDS means of these groups and produced a t-value of 1.31, $p>.05$. This t-value is somewhat less than that of the original groups.

A t-test was then applied to the MCSDS means and yielded a t-value of 3.33. This value is greater than that of the original groups ($t = 3.02$) but has the same associated probability ($p<.005$).

Anomalies.

There were two subjects (#'s 9 and 21) in the original High group whose scores were oppositional to the predicted direction on all three dependent measures. These

Table 2

Mean Scores of ESDS, MCSDS, and SRA Aggression From Hospital Records

	Hi	Lo
ESDA	21.36 (6.49)	24.72 (7.12)
MCSDS	12.40 (4.94)	16.72 (5.16)
SRA	13.40 (6.48)	5.52 (4.36)

Table 3

Mean Scores of ESDS, MCSDS, and SRA Aggression From Self-Report

	Hi	Lo
ESDS	21.76 (6.80)	24.32 (7.0)
MCSDS	12.16 (5.28)	16.96 (4.57)
SRA	14.68 (5.41)	4.24 (2.72)

subjects scored very high on social desirability and very low on the self-report of aggression. When this anomaly was discovered the author interviewed the subjects to seek some explanation for this unexpected finding. Both subjects were diagnosed as paranoid schizophrenic and were extremely guarded in their conversation. The records indicated that each of these subjects had, in the recent past been accused of sexual misbehavior with children, and in both cases this became the major focus of the interview as each denied guilt.

Subject #9 had recently been convicted of homosexually molesting a young child. The subject had been placed on probation after a number of court appearances on this charge, but in conversation appeared to be unaware that the case had been resolved. The subject believed that action on the case was still pending and that he would be returning to court in the near future. This was not in fact the case. He also believed that "some people" both at the court and at the hospital were "out to get him," and that he had to be constantly on guard against providing these people with anything that could be used against him. He mentioned more than once that he did not have any way of knowing (other than what I said, which clearly was not sufficient) what I might do with the information he provided on dependent measures of this study.

Subject #2 had, according to the records, been accused by his family of sexual misbehavior toward his own children, but no formal charges had been filed. The subject denied that there was any truth to the allegations and openly indicated that he felt his responses on the dependent measures showed him to be a "good guy."

In the Low (original) group there was one subject (#1) who evidenced anomalous scores on two of the measures. This subject's MCSDS score was 4 out of a possible 33, in a distribution with a mean of 16.32. His SRA score was one of the five highest in the Low group (10 out of a possible 33). The subject was a very bright, well-educated man who had been a pharmacist prior to the onset of difficulties associated with his chronic alcoholism. He was one of the three non-psychotics in the Low group. This subject was interviewed concerning his discrepant scoring and indicated that he had identified the underlying premise of many of the items in this measure. He stated that "This is just a test of lying" since " . . . most of those things are what we would like to do, but nobody really does them." When questioned about the SRA, the measure presented just after the MCSDS, he indicated that he had decided the purpose of the study was to identify liars and "I'm not

a liar, so I just answered it honestly."

Final comparisons.

The subjects were divided by Race (Blacks and Whites), age (by decades), and by diagnosis (psychotic and nonpsychotic), but no formal analyses were carried out due to the small number of subjects in each of these sub-groups. Comparisons of raw means across groups, and to their respective parent groups were done and suggested no clear trends associated with these factors.

C H A P T E R I V

DISCUSSION

The primary hypothesis of this study predicted that an inverse relationship would be demonstrated between social desirability and aggression. The data confirmed this hypothesis with respect to both measures of social desirability. Previous research in this area had demonstrated an inverse relationship between these variables in a static situation. The present study has demonstrated that the relationship in fact remains constant across many other natural settings. This finding has some bearing on the question of cross-situational consistency in behavior.

If we consider the disposition toward making socially desirable responses to be a "trait," these results demonstrate some stability for that trait across situations, within the specific sample studied. As herein employed, the term "trait" refers only to a behavioral pre-disposition which is evidenced in many, though not all, situations an individual experiences. If social desirability is assumed to be a trait, we would logically expect those who measure low on it to evidence some lack of social concern in their ongoing behavior. The overt expression

of aggression is not usually considered to represent socially desirable behavior. The data from this study show that on the average, those who display such a pattern of behavior (as indicated by the measures of aggression employed) score much lower on social desirability than do those who, again on the average, do not display such behavior (as measured by this study). The reverse of this condition is of course also apparent from these data. Subjects in this study who were not (by the measures herein used) overtly aggressive, scored much higher on social desirability than did their High-aggression counterparts.

Within the one-year time period sampled in the present study, a number of situations are represented. It must be conceded that the majority of these situations would have occurred within the milieu of the hospital and thus may not be representative of the totality of situations experienced by any given subject. It should also be noted that no claim of equivalence can be made as to the frequency or degree of provocations experienced by the subjects within this study. It can be stated, however, that there is a high probability that every subject, as a function of their patient-status, would have been exposed to some provocation during the year of hospitalization examined. Within these limits, it is

apparent that an inverse relationship, statistically significant on three out of four comparisons and in the same direction on the non-significant comparison, was evidenced between the variables of interest.

Bem and Allen (1964), and Hogan, DeSoto and Solano (1977) discuss at length some of the problems involved with research which involves "trait" as a term or as a concept. The former article, in discussing the cross-situational stability of traits, indicates that a common problem in attempts to demonstrate such stability involves the assumption by the investigator(s) that all individuals can be characterized by the trait under study, and will vary only by degree (the nomothetic assumption). The present study might be conceptualized as having sought to inversely associate two "traits": social desirability and aggressivity. Nomothetic assumptions were made about both, but subjects who conformed to such an assumption on aggression (as bi-polar opposites) were then selected for. This of course ignored the entire middle-range of possible subjects (those whose aggression scores from hospital records were between the values selected to partial out the extremes), whose variability of aggression might have masked the association with social desirability.

This is almost precisely the procedure both recommended and followed by Bem and Allen (1964): "Separate those individuals who are cross-situationally consistent on the trait dimension and throw the others out" (p. 512). These authors offer a detailed rationale for such a procedure which will not be re-capitulated here. It was employed in the present study simply because logic suggested that if an inverse relationship truly existed between the variables of interest, it should be most clearly exemplified in a comparison of subjects from opposite ends of the aggression continuum (which was assumed by the author to exist).

A second hypothesis of this study related to the self-report of aggression. It was predicted that subjects would be relatively honest in such self-reporting and that there would accordingly be a positive correlation between High and Low-Aggression group placement based on hospital records, and self-report scores on the SRA. The r_{pb} of .588 clearly supported this hypothesis and with a significance level of .001 we can safely conclude that this study provides some support for the validity of self-report of aggressive behavior against behavioral/observational indices (hospital records). It should be noted that since staff members recorded the instances of aggression which were used to define the High-Aggression

group, they may well have communicated their impressions of the aggressivity of given patients to the patients themselves. Given this, it is possible that a given patient's own perception of his aggressive behavior and its frequency could be influenced by what the staff has told him about that aspect of his behavior. If this in fact occurred, the measures would no longer be independent and the r_{pb} would thus be spuriously inflated. While this is mentioned as a possibility, two factors can be cited to argue against it: the fact that the SRA asked about very specific behaviors and the fact that this finding is consistent with those of Lindzey and Tejessey (1956) and Wallace and Sechrest (1963), in that both of these studies compared self-report of aggression to protective measures of aggression, with peer-ratings as the criterion. Both of these studies found self-report to be significantly more accurate than projectives in these measures of aggression. While these studies also used an "other's rating" as the criterion measure, both used students as subjects, presumably less subject to persuasion from peers than might patients be from staff.

The findings of the present study suggest that in assessing the efficacy of treatment measures with aggressive subjects, self-report may be a relatively valid outcome measure, within the previously discussed limits.

Aggressive subjects may be less inclined toward response-dissimulation based on the social desirability of a given test item and within this study are relatively honest in reporting their aggressive behavior when this is compared to a behavioral criterion based on observational data. This suggestion relates only to their intrinsic motivation to dissimulate and does not address the situation-specific possibility of extrinsically motivated dissimulation.

In an earlier section of this report it was predicted that the pathology-content of the ESDS items would tend to blur the scores across groups on this measure, thus reducing the magnitude of the between-groups difference as compared to the between-groups difference of the MCSDS. The data demonstrated this predicted difference in magnitude in favor of the MCSDS, which attained a significance level of .005 as compared to the .05 significance level of the ESDS. It is suggested that this did indicate that a blurring of the ESDS scores might have occurred due to the combination of a pathology-content in its items, and the use of psychiatric patients as subjects. When a median-split of the SRA scores was used to re-group the subjects, the new across-groups ESDS means while diverging in the predicted direction, did not reach statistical significance.

While no definite cause for this happenstance can be established, it is suggested that the posited blurring of ESDS scores due to the reasons cited, may well have contributed to the failure to attain significance. Since there was, through this re-grouping of the subjects, a slight increase in the difference between means on the MCSDS, it may also be suggested that random error contributed to the slight deflation in the mean-difference on the ESDS and a slight inflation of the mean-difference on the MCSDS. The significance level of the mean-difference on the MCSDS was not altered through this re-grouping of subjects, but remained at .005, thus demonstrating the inverse relationship on this measure through two separate measures of aggression.

The discussion to this point has been concerned with the internal, or personality-determined motivation to respond in a socially desirable manner. The data from this study may provide some support for the contention that such a trait, or disposition, does exist. As was alluded to in the earlier discusssion of the validity of self-report with aggressive subjects, there can also be an external, or situationally-determined motivation to project oneself in a social-desirability mode. Subjects 9 and 21 in the present study displayed totally anomalous scores. Both of these subjects did, according

to hospital records, fairly frequently express their aggression both verbally and physically. Each of them emphatically denied this in their SRA scores (5 and 4 respectively, in a distribution with a mean of 13.40), and they both endorsed items on the social desirability measures which were antithetical to the kind of dispositions one would ascribe to them based on their hospital-record data. These subjects obviously did not conform their ongoing behavior to socially desirable characteristics, yet were intent on projecting themselves in a highly socially-desirable manner on the measures. Interviews with these subjects disclosed that each believed himself to be, and to some degree was, in legal jeopardy due to allegations of socially undesirable behavior. Each appeared, therefore, to have a situationally determined need to present himself in the most favorable (socially desirable) light, for defensive reasons.

The normative data for the MCSDS presented by Crowne and Marlowe (1964) includes the means for a group of female employees of an insurance company who were told that the scores would be seen only by the experimenter ($n = 88$, $\bar{X} = 15.42$), contrasted with the mean of a group of female employment applicants to the same company, who were led to believe that the scores would be considered in hiring decisions ($n = 285$, $\bar{X} = 24.62$). The normative

data included the means of twenty groups, composed of both male and female groups which included students, psychiatric patients and prisoners as well as the females associated with the insurance company. The mean of the female employment applicants exceeded all others. Even allowing for the difference in the size of the groups, the more than nine-point difference in the means of the insurance company females suggests that a powerful external factor which is seen by the subjects as being in some way related to the potential use of the MCSDS scores, can cause them to be grossly inflated. Like the insurance company applicants, subjects 9 and 21 of the present study evidenced the highest MCSDS scores in their group (27 and 22, respectively).

In conclusion, while the relationship of interest was demonstrated with both measures of social desirability, the difference in magnitude the relationship evidenced between the ESDS and the MCSDS clearly favored the MCSDS. For this reason, it may be suggested that further research concerning these variables which may employ psychiatric patients as subjects might more profitably restrict itself to the use of the MCSDS as the exclusive measure of social desirability. It should also be noted that the SRA measure used in the present study could be improved through greater specificity in the frequency

choices provided. This would reduce the potential for differential interpretations of the frequency choices.

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Appendix A

Aggression point-scale - for use with hospital records in the development of dichotomized High & Low groups.

Each category shall define a type of report and shall have a specific point value associated with it. A patient's score shall be the sum of all points accumulated during a review of his records over the past year.

1) A specific report of an unarmed fight or assault including one or more punches or kicks to an adversary = 5 points. Five more points will be added for each additional adversary actually struck by the patient in the same incident.

2) A specifically described incident of a fight or assault taking place outside of the hospital involving one adversary/victim (e.g., "Pt. returned from weekend pass by relatives due to assault on wife. Wife states that pt. became verbally abusive over minor incident and just kept screaming and getting madder until he suddenly slapped her 2 or 3 times. Wife screamed and began to cry, pt. became contrite and tearful." This incident would be scored as 5 points, since the actual assault would encompass the less severe verbal aggression which preceded it.

3) A general report that the pt. has frequently gotten into fights:

During last six months	=	10 points
During last two years	=	15 "
Over 3-5 years	=	20 "
For more than 5 years	=	25 "

4) A general report that pt. has been physically assaultive toward one or more members of his household:

During last six months	=	10 points
During last two years	=	15 "
Over 3-5 years	=	20 "
For more than 5 years	=	25 "

5) A specific report of an incident of verbal abuse toward staff or other pt.(s) = 3 points.

6) A general report that the pt. is verbally abusive (insulting, threatening, etc.) toward others = 5 points.

7) A specific incident report of the pt. engaging in physical aggression toward objects (e.g., breaking windows, kicking furniture, throwing objects at walls, windows or floors, et.) = 4 points.

8) A general report that the pt. engages in the above type of behavior which refers to or implies more than one such incident = 6 points per such notation.

9) A specific report of the pt. using or attempting to use a weapon to injure someone ("weapon" shall be any object not a part of the pt's body with the exception of shoes and attached prosthetic devices) = 10 points.

10) A general report that a pt. has used or attempted to use a weapon to injure someone which refers to or implies more than one such incident = 20 points per such notation.

Sepcific incident reports which refer to aggressive behavior but are not readily classifiable under the preceding categories will be scored individually on the basis of the perceived intent of the pt. as implied in the description of the incident (e.g., a report that a pt. had "attempted to strangle" another pt. would be scored 10; a report that a pt. had "put his hands on the throat of another pt. and then removed them without further indicent" would be scored from 0-5 points, based on the report writer's judgement of the pt.'s intentions concerning the incident. A report that a pt. had "grabbed another,wrestled him to the floor and attemped to gouge out an eye," "bite off an ear," or perform some other harm-doing behavior which did not include (or was not restricted to) a punch or a kick but as in the above two instances would exceed a blow or kick in severity, would be scored 8 points (more than a punch, but less than an attempted murder). A report that a pt. had thrown/wrestled another to the floor without further harm-doing behavior would be less severe than a blow or kick and would be scored 4 points). Every attempt will be made to avoid duplication of scored items within a given pt.'s record.

Appendix B

Please read each item carefully and rate how you feel it applies to your behavior during the past year. This information will not become a part of your hospital records and will not be used against you in any way. The information is being collected as part of a research program which is seeking to learn, among other things, how accurately people rate themselves on these behaviors when compared with how other people may have rated them. Please make an "X" on the line opposite the rating which you choose for each item.

1) I get into fights — Never___Rarely___Fairly often____ Frequently___

2) I insult someone — Never___Rarely___Fairly often___ Frequently___

3) I yell at someone — Never___Rarely___Fairly often Frequently___

4) I swear at someone — Never___Rarely___Fairly often___ Frequently___

5) I hit someone — Never___Rarely___Fairly often___ Frequently___

6) I pick a fight with someone — Never___Rarely___Fairly often___ Frequently___

7) I punch something — Never___Rarely___Fairly often___ Frequently___

8) I talk about hitting someone — Never___Rarely___Fairly often___

9) I threaten someone — Never___Rarely___Fairly often___ Frequently___

10) I kick something

Never___Rarely___Fairly often___
Frequently___

11) I smash something to pieces

Never___Rarely___Fairly often___
Frequently___

Appendix C

Informed Consent Sheet

You are being asked to participate in a research project after having been selected for the study through a search of hospital records. The general purpose of this study is to compare information from some structured survey forms to behavior. The reason you were selected and all of the facts regarding this study will be explained to you at the end of this session whether you choose to participate or not. If you agree to participate you will be asked to fill out three paper-and-pencil forms which ask for information about some of your attitudes and behaviors. You will be asked to fill these out as honestly as you can, with the clear understanding that the information you provide on these forms <u>will not</u> become part of your hospital records and will be used <u>only</u> for purposes of this study. The information you thus provide will be added in with information from other people since the purpose of this study is to look at and compare information about <u>groups</u> of people and not about individuals. You are being asked to do this strictly on a voluntary basis, and you may refuse to participate if you so choose. There are no rewards for participating nor penalties for refusal.

If, after having the above facts read to you, you agree to participate, please sign this sheet at the bottom.

Please be aware that even after singing this sheet you are still free to withdraw should you change your mind.

The above facts have been read to me, I understand them and I agree to participate.

Signed_____

Date_____